MEDICAID REVIEW FORM

FI-Related Program

FROM:

TO:

Date:
Worker Name:

Telephone:

BG#:

We must decide if you or your children can continue to get Medicaid. Please
- answer all questions on this form,
- attach the requested proof of information,
- sign this review form, and
- return this form to us by

If you need help with this form or have questions, please call your Medicaid worker at the telephone number listed above.

Tell us who in your family lives with you. Fill in the requested information. You do not have to give us citizenship information or Social Security numbers for people who do not get Medicaid, but Social Security numbers may help us get information we need to decide if you can still get Medicaid.

Name	Relation to You	Marital Status	Birthdate	Sex M or F	U.S. Citizen	Social Security Number

Tell us how much income your family has. Enter GROSS PAY not take-home pay. Enter zero (0) if you are unemployed.

Your Income From Employment	Other Parent's Income from Employment
Employer's Name and Telephone Number:	Employer's Name and Telephone Number:
Amount you earn each pay period before taxes: $ _____	Amount other parent earns each pay period before taxes: $_____
☐ Weekly ☐ Twice a month ☐ Every Two Weeks ☐ Monthly	☐ Weekly ☐ Twice a month ☐ Every Two Weeks ☐ Monthly

* Please send your pay stubs for the last four weeks and proof of all other income received in the last month.

Other Income	Amount	How Often Is this Income Received?	Which Family Member Gets This Income?
Child Support	$		
Alimony	$		
Social Security Payment	$		
Unemployment Benefits	$		
Other (Please explain)	$		

* Please send DHHS proof of the income listed above other than Social Security.

Do you pay someone to take care of your child(ren) or a dependent parent while you work?

☐ Yes. Number of children/parents for whom you pay for care: _____ Amount $ _____
Attach verification of amount.

☐ No

Do any family members living with you pay child support for a child outside the home?

☐ Yes - Fill in the information requested below

☐ No

Name of Person Paying Out: _____

For Whom Is Payment Made? _____

Amount: _____

How Often? _____

Does your family have health insurance other than Medicaid? ☐ Yes ☐ No

If yes, what is the name of the insurance company? _____

Who is covered by the insurance? _____

What is the policy number? _____

* Please send DHHS a copy of the card.

PLEASE READ THE STATEMENTS BELOW CAREFULLY AND SIGN THE FORM.

- I understand that Medicaid coverage will be redetermined based on this form.
- I understand that I must report all changes in my household situation within 10 days.
- I understand that if I give wrong information I may have to pay back money for benefits I received while I was ineligible.
- I understand that by signing this form, I am saying that I have told the truth.
- I understand that I have the right to a fair hearing if I disagree with a decision made by DHHS.
- I understand that my right to third party payments for medical care will be assigned to the State.

* If you do not attach verification of income, your review cannot be processed.

I certify that all of the people listed on this form who are receiving or requesting Medicaid are U.S. citizens or lawful immigrants.
I certify that the information I have given in this form is true, and I give the Department of Health and Human Services permission to make any necessary contacts to check my statements.

WKR002 - Revision Date 03/2003

_____ Signature of Beneficiary or Authorized Representative

_____ Date

_____ Telephone